The Short-Doyle Program

Its Past and Its Prospects

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THE COMMUNITY MENTAL HEALTH Services Act of 1957 ushered in a revolution in the provision of psychiatric services to the mentally ill, the mentally retarded and other mentally disordered persons in the State of California. The concept underlying this legislation, popularly known as the Short-Doyle Act, is that psychiatric treatment is best provided as early as possible in the course of the disorder, with the minimum disruption of the day-to-day existence of the patient.

There are several assumptions of a clinical nature implied by this concept:

- Psychiatric disability need not be either permanent or total.
- Early intensive treatment is more effective and less expensive than long-term custodial care.
- The less the life of the patient is disrupted, the more easily can the maximum social restoration be achieved.

There are also several administrative implications to the concept:

- Programs developed at the community level have a high probability of meeting the perceived needs and effectively using the available resources of that particular community.
- The ongoing development of the program is likely to be responsive to the community's changing perception of its need.
- The local administration of the program requires and reinforces the community's acceptance of the responsibility for providing psychiatric services to its members.

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In brief, the Short-Doyle Act[2] enables communities to establish local mental health services and receive partial reimbursement of the cost from the state. Reimbursement by the state for the cost of operating such services is provided on the condition that the community meets certain requirements. A "community" is defined as a county; a city with more than 50,000 people; two or more counties; two or more cities whose combined population is more than 50,000; or a combination of cities and counties. A community can receive financial support from the state, provided at least two of the following services are included in the program:

1. Psychiatric outpatient treatment.
2. Psychiatric inpatient treatment in a general hospital or in a psychiatric hospital affiliated with a general hospital.
3. Rehabilitation services for the psychiatrically disabled to enable them to function at the best possible level socially, emotionally, vocationally, and physically.
4. Consultation by qualified mental health personnel to the professional staffs of public and private agencies and to individuals practicing privately in the community, to help them deal more effectively with mental health problems of their clients or patients before they are so severe as to require psychiatric treatment.
5. Mental health information and education services to the public and to key professional groups to build a broader understanding of mental health and mental disorders and to acquaint them with sources for help when it is needed.

Direct treatment services are provided only to persons who cannot obtain care from private

sources for any reason—for example, because they cannot afford it or because it is too far away. Patients pay what they are able for treatment, but payments cannot be in excess of the cost of providing the services. Each community is required to set up a fee schedule. The Department of Mental Hygiene will advise on fee schedules, but each community establishes its own. Services are provided to those who voluntarily seek treatment and to those ordered to do so by the court. All types of psychiatric disorders can be treated—mental illness, mental retardation, alcoholism, senility, character disorders. Several methods of providing services are permissible. Contracting allows flexibility in program planning and makes possible the coordinated and effective utilization of all existing psychiatric resources. The community submits a proposed program of mental health services to the state for approval annually. The state reimburses the community for the cost of providing these services in the amount approved by the following formula: ,

For services which existed previously and have been incorporated into the Short-Doyle program —50 per cent.

For new services developed since the community's establishment of a Short-Doyle program —75 per cent.

The Short-Doyle Act places no ceiling on the amount of State reimbursement to a community. However, the annual total allocation is authorized by the Governor and the State Legislature and total reimbursement cannot exceed the allocation.

The State establishes the standards for community mental health services supported by state funds. It does so in consultation with the Conference of Local Mental Health Directors. The Conference consists of all regularly appointed directors of community mental health services and program chiefs as defined in the regulations. These standards encompass the quantity and quality of local mental health services; the qualification of professional and technical personnel employed; and the record-keeping procedures of each program which are relevant in terms of evaluation and fiscal responsibility.

The Growth and Scope of Short-Doyle Programs

The first programs began receiving reimbursement for services as of January 1958. Six counties constituted the initial group with approved programs. For the first half year of operation, $786,000 was appropriated for the fiscal year 1957-58; for the first full year of operation, 1958-59, $1,600,000 was appropriated. Today, there are 41 approved local mental health programs.[8] Of the estimated 19,000,000 population of the State of California, 16,500,000 reside in the areas covered by these 41 approved programs. Three of the programs are operated by cities or combination of cities, such as Berkeley, San Jose and the Tri-City Program in Los Angeles County. All other programs are operated as county programs. Several programs serve additional counties by contractual arrangements, for example, Sierra County contracts with Plumas County for services, and Del Norte County contracts with Humboldt County. All but 17 of the 58 counties in California have Short-Doyle programs, either by direct operation or by contractual arrangements. The counties without Short-Doyle services with the exception of three counties, San Bernardino, Riverside, and Imperial, have small populations. These three counties are the only three in the State of California with a population over 50,000 that are not participating in the Short-Doyle program. The other counties have less than 50,000 population and include such counties as Modoc, Alpine, Mono, Inyo, Trinity and others, several of which have less than 10,000 population. Alpine County has an approximate population of 400.

All programs currently approved provide outpatient clinic services and 26 of the programs provide inpatient services in general hospitals or in psychiatric hospitals affiliated with a general hospital.[8] The growth in size of programs has been particularly large during the past few years. Outpatient visits have expanded as have inpatient admissions to the psychiatric units. Examples of this and comparison with state hospital admissions for the mentally ill for the last five or six fiscal years are as follows:

- For the year ending 30 June 1962, inpatient admissions to Short-Doyle programs totaled 7,445; admissions to the state hospitals for the mentally ill totaled 24,550.
- For the year ending 30 June 1967, projected admissions based on data to date indicate that inpatient admissions to Short-Doyle inpatient facilities will total 44,450 as compared with admissions of approximately 27,000 to state hospitals. Admissions to outpatient psychiatric units in Short-Doyle have increased from 15,459 for

the year ended 30 June 1962 to an estimated 84,500 for the year ended 30 June 1967. Likewise, the resident population of the state hospitals for the mentally ill has declined from 35,743 for the year ended 30 June 1962 to an estimated 23,920 for the year ended 30 June 1967.

Reimbursements by the state for 1966-67 totaled $18,600,000. For the current fiscal year, $23,901,030 has been budgeted for reimbursement for Short-Doyle programs. The increase in the volume of service has paralleled the increase in the number and the cost of operations of these programs.

Effect on State Hospital Admissions

Studies have been made by the Department of Mental Hygiene in an attempt to determine the effect of Short-Doyle services on state hospital admissions. This is a difficult figure to determine precisely, since many factors can influence state hospital admissions, including insurance programs which pay for private care, the effect of Medicare and Medi-Cal and other programs.

In general, we have found the following patterns: A reduction in state hospital admission rates has occurred in counties with Short-Doyle inpatient services.[1] Counties with Short-Doyle programs which do not include inpatient services but do have outpatient services have increased admission rates to state hospitals for the mentally ill; but those counties without any Short-Doyle program at all have a percentage increase in admissions to state hospitals for the mentally ill more than three times that of the counties with Short-Doyle programs that have outpatient services but no inpatient services. Specifically, counties with inpatient services in Short-Doyle show a 10.4 per cent reduction in the admission rate to the state hospitals for the mentally ill. Counties with Short-Doyle programs without inpatient services, but with an outpatient clinic show a 14.5 per cent increase in rate of admissions and counties with no Short-Doyle program at all have a 45.7 per cent increase in rate of admissions.*

The emphasis for the future, however, has to be not just in continuing what we are now doing, but in modernizing and updating and moving in new directions. For example, it is hoped the Short-Doyle Act will be revised this year, and proposals have been made to the administration to revise the services provided from the existing five services established ten years ago to the ten services now provided in the regulations relating to the Federal Community Mental Health Center program. The proposed ten services would consist of: inpatient services; outpatient services; partial hospital services such as day care, night care and weekend care; emergency services; 24 hours a day consultation and education services available to community agencies and professional personnel; diagnostic services; rehabilitative services; pre-care and after-care services in the community; training; research and evaluation.

These ten services can provide a much broader range of service. Care could be provided for the mentally retarded on a much broader scale if these changes are made. Providing services similar to those contained in the federal regulations should make it easier for local programs to qualify for the federal staffing grants and for the federal construction funds. Utilization of the staffing grants can reduce both the county and state shares in Short-Doyle and result in considerable saving of state and local dollars. It would be possible through these revisions to submit an application for Short-Doyle which could simultaneously qualify for federal subsidy under the Community Mental Health Staffing grants.

When a local program has been able to interpose itself between a patient and a state hospital by means of a screening program before formal commitment proceedings have been instituted, or when it has been able to provide some alternative local service, the effect on mentally ill commitments has been most significant. For example, in one county in this state in 1962 there were 1,109 mental illness petitions filed and 862 commitments to state hospitals. In 1965, after initiation of a screening program, the number of petitions was 542 and there were 415 commitments. Other Short-Doyle programs with procedures for screening applications for commitment before a commitment paper is ever taken out for admission to a state hospital, have had similar experiences.

At present 26 community mental health service programs under the sponsorship of Short-Doyle provide pre-petition or pre-commitment evaluations or both for commitment to hospitals for the mentally ill. Twenty of these 26 counties provide this service for all patients committed to the state hospitals. It might be interesting to note at this point that 30 community mental health services

*The changes reported were the differences between data for a two-year period ended 30 June 1960, and a two-year period ended 30 June 1966.

under the sponsorship of Short-Doyle provide some psychiatric aftercare service to former state hospital patients. Ten Short-Doyle programs provide day treatment centers similar to those proposed for discontinuance in San Francisco, Los Angeles, and San Diego.

Programs for Retarded

Another area of interest in relation to state hospital admissions is that of retardation. Recently there has been greater interest on the part of local programs in providing services for the mentally retarded. Seven counties with Short-Doyle programs now provide some combination of screening, diagnosis, evaluation, counseling and referral services for the mentally retarded. They are Alameda County, Contra Costa County, Plumas County, San Francisco County, San Mateo County, Santa Clara County and Santa Barbara County. In some of these counties, the services include complete diagnostic services in relation to preadmission screening for a state hospital.

Considerable discussion has taken place as to the role of the Short-Doyle program in the treatment of alcoholics. Questionnaires exploring the subject of service to alcoholic patients have been returned from 23 of the 41 counties with Short-Doyle programs. The information obtained indicates that for the fiscal year ended 30 June 1966, in 12 of the 23 counties replying, more alcoholics were treated under Short-Doyle programs than were committed to the state hospital. Six of the 23 counties screened more than 50 per cent of petitions filed for commitment for alcoholism in the counties, and in 11 of the 23 counties 50 per cent of commitments to the state hospitals for alcoholism were evaluated. It should be noted that the data from these 23 programs indicated that in these programs there were 7,350 discharges of alcoholics from inpatient care and 3,242 from outpatient programs, a total of over 10,500, in contrast to 1,778 alcoholism commitments to state hospitals from these same counties in the year ended 30 June 1966.

The Future of Community Mental Health Services

The experience accumulated during the past ten years has validated the basic concept. It has also done much more. It has afforded all of us involved in providing mental health services with an opportunity to examine the total constellation of services available and how we use them.

There are gaps in service, both categorical and quantitative. There is duplication of services. There is discontinuity of service. There is confusion as to reponsibility for services. There is inadequate coordination of psychiatric, nonpsychiatric and nonmedical services. There is the all-too-human tendency for the staff in various agencies to perceive services within the limited context of their own agencies. The quality of the information upon which much of our planning is based cannot withstand scrutiny. Planning proceeds from many foci and in many directions.

These deficiencies are cited not to heap coals of fire upon the heads of those of us who have responsibility in the field but because they define the direction in which we must move. They are cited because the revolution ushered in by the Short-Doyle Act of 1957 has paved the way for a second revolution in the provision of mental health services in the State of California. We are confronted by the challenge of change generated by change. The history of mental health in California for the next ten years will be a record of how well we have met the challenge.

We can now restate the basic concept in broader terms—mental health is a community affair. A member of the community is entitled to mental health services in the same way and to the same extent that he is entitled to the other services that preserve and protect the health and welfare of the community. He should not be rejected and banished from the community as though his illness had offended God and man.

It is the responsibility of the community leaders to define the mental health needs of the community, to inventory the existing resources of the community, and carefully and systematically to plan, organize and implement a program of mental health and related services appropriate to the needs of the community. The system that is developed must be coordinated, accessible, flexible and capable of changing to meet changing need.

Our perception of the mentally ill must change. We must counteract the tendency inherent in the medical model to be primarily concerned with pathology. It is far more constructive and effective to define the resources that the patient retains and attempt to expand these to correct or compensate for his psychiatric disability. This concept flows quite naturally from the basic concept that mental illness is neither permanent or total. It casts the treatment of the mentally ill in a much more positive frame of reference and favor-

ably influences the climate of treatment for patient and staff alike. We must identify those in need of mental health services as "community patients." Our historically rooted identification of the mentally ill and disordered as "state patients" for whom the state has direct responsibility has hindered the development of community mental health services. What local mental health official would dare suggest that local government duplicate services provided by the state?

This categorization of patients often begins with commitment. Although the laws permit wellnigh unlimited discretion to the court in the matter of commitment, the extent to which this discretion is exercised is limited. This strongly suggests that some modification of the laws related to commitment is in order in those instances in which the belief that the mentally ill are a danger to themselves or society is not supported by fact.

The state responsibilities in support of the development of local programs are several:

- The first and foremost is fiscal. The taxing power of the state must be reflected in the financial support of local services. The limited local tax base makes this imperative.
- The state must continue to establish standards and ensure compliance.
- It must eliminate those direct state services in the community which it requires local services to establish.
- The state must raise the standards of staffing and services in its own institutions to the level that it demands of private and county institutions.
- It must support the continued development of programs of training, research, specialized treatment and demonstration of treatment methods in the state hospitals that are beyond the capability of small jurisdictions. It must provide bases of support in the state hospitals for local programs as pools of manpower, specialized skills and training facilities.
- It must provide continued consultation and planning assistance to local government.

There also needs to be further discussion on the question of relationship of the Short-Doyle program to the Medi-Cal program. The implications of this program for the mental health field are considerable. Considerable time and attention are being given to the relationship of these two programs with the goal of making the maximum use of both, with a minimum of conflict and confusion.

In the future, emphasis on community mental health will also be made in provision of services for crisis care, emergency care and pre-commitment screening for patients who are candidates for admission to the state hospitals. These services can considerably reduce the need for a person to go to a state hospital for treatment. It is hoped that in the not too distant future, no patient will be sent to a state hospital on a committed status unless it is determined first of all that commitment is necessary and, next, that hospital care is not available locally. Admission to a state hospital would only occur after screening by a local program or a local service and only when the necessary treatment resource cannot be provided locally.

The same concept would extend to the patients who return to the community, so that any psychiatric services a patient may require following his release from the state hospital would be provided from a local program. In this way, there would be a blending and combining of state care and local care with an continuum of services available to the patient regardless of the sources of funding, whether it be through subvention or 100 per cent state financing. This would also follow the concept and ideas envisaged in the community mental health center approach where a wide variety of services is available to the individual and these services are made available to him when he requires them, where he requires them and when he requires them, without delay, without waiting lists, whatever his age and whatever his diagnosis. A treatment program is developed to fit his requirements rather than trying to fit him into a predetermined program.

It must be noted that whereas sensitivity to local needs increases as one proceeds from the federal to the local level, administrative sophistication may tend to increase in the opposite direction. This has definite implications for program development. Further, even at the local level, governmental organization is an extremely complicated affair and program development will be decidedly influenced by the administrative structure within which it is established.

The major responsibility for collecting the data upon which such a plan for mental health services must be based is a state responsibility. A monitoring and forecasting system is required that will continuously collect data on our total mental health manpower, funding and services. This sys-

tem must record what is available, the extent to which it is utilized and the rate at which it is utilized. Criteria of effectiveness must be agreed upon, and the results of services measured against the criteria. The unit cost of the services provided must be determined and costs must be measured against effectiveness. Only when such information is available can mental health planning be conducted on a sound and systematic basis.

Much that relates to systems has been implied here and should perhaps be stated explicitly. We need to develop a systems method, applicable to the planning, operation, evaluation and continuing adaptation of a mental health services delivery system that will be comprehensive and coordinated, and will provide continuity of service and freedom of choice where applicable. The system must be community based and administered. It must be designed to meet the needs of patients. It must be pragmatic and goal oriented. Each component in the system, individual or agency, whatever its self-determined goal, must have as a superordinate goal, the goal of the system; early intensive appropriate treatment with the maximum social restoration.

To strive for such goals might well lay one open to the charge of being idealistic. The truth of the charge notwithstanding, if we achieve them during the next ten years, we will have built well upon the accomplishments of the past ten years.

For those who find these ideas too visionary, may I offer (from *Joel*) *"your old men shall dream dreams, your young men shall see visions,"* and (from *Proverbs*) *"where there is no vision, the people perish."*

REFERENCES

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